211 CMR 43.00: HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

SECTION

43.01: Authority

211 CMR 43.00 is promulgated in accordance with the authority granted to the Commissioner of Insurance by M.G.L. c. 175J §9, M.G.L. c. 176D §11, M.G.L. c. 176G § 17 and M.G.L. c. 176O, §17.

43.02: Applicability

(1) No organization may provide or arrange for health services to enrolled members who are Massachusetts residents in exchange primarily for a prepaid per capita or aggregate fixed sum without being licensed in accordance with the provisions of 211 CMR 43.00.

(2) A university or college health service or plan shall not be not required to obtain a license under M.G.L. c. 176G or 211 CMR 43.00 where membership in such service or plan is limited solely to enrolled students, faculty, employees, and affiliates, and their dependents.

43.03: Definitions

As used in 211 CMR 43.00, the following words mean:

Administrative Supervision, action by the Commissioner to apply and carry out the provisions of chapter 175J.

Agent, any person not employed by an HMOwho markets or sells HMO benefits, other than a broker licensed pursuant to M.G.L. c. 175, § 166.

Commissioner, the Commissioner of Insurance, appointed pursuant to M.G.L. c. 26 §6 or his or her designee.

Controlling Interest, the possession of the power of a person or persons to direct or cause the direction of the management and policies of the HMO, whether through ownership of voting stock with the present power to vote, or proxies representing more than 5% of the voting stock of any other person or persons, by contract other than a commercial contract for goods or nonmanagement services, through official positions or positions with, or corporate office or offices held by, the persons or otherwise.

Emergency Medical Condition, a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

Evidence of Coverage, any certificate, contract, or agreement including riders, amendments and supplementary inserts, issued to a member in accordance with M.G.L. c. 176G, §7 and 211 CMR 52.00, specifying the benefits to which the member is entitled.

Finding of Neglect, a written determination by the Commissioner that the HMO has failed to make and file the materials required by M.G.L. c. 176G, M.G.L. c. 176O, 211 CMR 43.00 or 211 CMR 52.00 in the form and within the time required.

Health Services, at least reasonably comprehensive inpatient, outpatient, and emergency care services including: preventive services, such as immunizations; periodic health exams for adults; prenatal maternity care; well child care including vision and auditory screening; voluntary family planning; nutrition counseling, and health education; and also including pediatric care; and a minimum of 100 days in a 12-month period or 365 lifetime days of noncustodial care in a skilled nursing facility; and which may include, but not be limited to chiropractic services; optometric services; and podiatric services.

Managed Care Bureau, the bureau in the Division of Insurance established by M.G.L. c. 176O, § 2.

Member, any individual, and each covered dependent, who has entered into a contract, or on whose behalf such an arrangement has been made, with an HMO for health services.

NAIC, the National Association of Insurance Commissioners.

Office of Patient Protection, the office in the Department of Public Health established by M.G.L. c. 111, § 217(a).

Organization, an individual, corporation, partnership, business trust, association, organized group of persons whether incorporated or not, or any line of business division, department,

subsidiary or affiliate of any thereof and any receiver, trustee or other liquidating agent of any of the foregoing while acting in such capacity.

Provider, any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

Service Area, the geographical area as approved by the Commissioner within which the HMO has developed a network of providers to afford adequate access to members for covered health services.

43.04: Licensing

(1) Application. Any organization seeking licensure or license renewal as an HMO under M.G.L. c. 176G must submit an application that contains at least the following information in a format specified by the Commissioner. The organization must submit a copy to the Office of Patient Protection.

(a) Internal Operations Plan.

1. A copy of the basic organizational documents, such as articles of incorporation, articles of association, partnership agreement, trust agreement or any other applicable document establishing the HMO and all amendments thereto;
2. A list of the Board of Directors or similar policy-making body, including the name, principal occupation and employer of each person;
3. A copy of the by-laws, rules and regulations, or other similar document regulating the conduct of the applicant's internal affairs;
4. A copy of the organizational chart with titles in the areas of marketing, administration, enrollment, grievance procedures, quality assurance, contract negotiation and financial matters;
5. A narrative of the health care plan, facilities and personnel including, but not limited to, the organizational structure, a description of the service area and provider network, the roles, functions, responsibilities of, and interrelationships among providers and the methods of provider reimbursement and risk-sharing arrangements;
6. An inventory of owned, operated, contracted and participating provider facilities including, but not limited to, hospitals, skilled nursing facilities, home health care and medical care services;
7. For HMOs who manage their own health care facilities only, a legal opinion from the General Counsel of the Department of Public Health indicating whether the applicant has complied with the requirements of M.G.L. c. 111;
8. A power of attorney authorizing the Commissioner to accept service of process for any legal actions commenced against an HMO not domiciled in the Commonwealth of Massachusetts; and
9. For staff model HMOs only, an inventory of full-time equivalents of providers by specialty with physician to population ratios.

(b) Utilization Plan.

1. A statement of inpatient and outpatient utilization review measures; and

2. statement of actuarial review and certification of actuarial assumptions made regarding utilization as applied to projected financial statements.

(c) Quality Assurance. A detailed description of the quality assurance system or a certification that the description of the quality assurance system is included in an accompanying accreditation filing submitted under 211 CR 52.00.

(d) Marketing Plan.
1. A marketing plan describing the service area population and existing medical care utilization rates for inpatient and outpatient services in existing facilities in the service area;
2. The anticipated enrollment for the HMO, and the service area population and utilization rates projected for health services delivered in the HMO's service area; and
3. A statement of the size, organization, accountability and marketing methods of the marketing staff.

(e) Member Services.
1. A copy of the evidence of coverage for each different product to be offered or a certification that the evidences of coverage are included in an accompanying accreditation filing submitted under 211 CMR 52.00, and a description of the HMO's process for distributing such evidences of coverage to members;
2. A plan for the yearly publication and distribution to members of rates, medical care service hours, location and telephone number(s) for normal service, and for emergency service;
3. A map of the service area and a list of towns included;
4. A copy of the provider directory or a certification that the provider directories are included in an accompanying accreditation filing submitted under 211 CMR 52.00, and a description of the process for distributing provider directories to members;
5. A statement of the confidentiality procedures used to maintain member confidentiality involving medical records, grievances, quality assurance studies and contractual provisions in provider agreements;
6. A detailed description of the formal internal grievance systems including procedures for the registration of grievances and procedures for resolution of grievances, with a descriptive summary of written grievances made in the areas of medical care and administrative services; and
7. For renewal applications only, the total number and disposition of malpractice claims and other claims relating to the service or care rendered by the HMO made by, or on behalf of, members of the HMO that were settled or resulted in a judgment during the year by the HMO.

(f) Contractual Arrangements.
1. A copy of the forms of group contracts or certification that the group contracts are included in an accompanying accreditation filing submitted under 211 CMR 52.00;

2. A copy of every contract form made or to be made between the applicant and any providers of health services or certification that the contract forms are included in an accompanying accreditation filing submitted under 211 CMR 52.00;
3. Administrative contracts including management and marketing contracts, and rental and leasing agreements;
4. Written procedures for the prior review and approval by the HMO of provider subcontracts, including, but not limited to, the language requirements and other standards by which the HMO reviews the subcontracts;
5. Written procedures by which the HMO maintains on file original signed provider contracts and copies of signed provider subcontracts; and
6. For the purposes of 211 CMR 43.04(f), "contract form" means a single copy of each generic contract used for each type of provider and not a copy of every contract signed between the HMO and provider.

(g) Premium Rates.
1. Rates for all insured products offered, as applied to projected financial statements;
2. A statement of the reasons for proposed rates and benefits, their effective dates and their marketing impact;
3. A comparison of current and proposed rates listing premium cost components as percentage of premium;
4. An explanation by the HMO's actuary supporting the actuarial assumptions and calculations utilized in the submission. The derivation of the rates must be clear and complete. All assumptions used must be stated and supported, and any mathematical factors used must be both defined and derived.

(h) Financial Plan
1. Audited financial reports for at least the prior three fiscal years of the HMO's existence. Reports must be separate for HMOs operated as a line of business, division, department, subsidiary or affiliate as provided in M.G.L. c. 176G, §3;
2. Financial statements as listed below which project the results of operations for the next three calendar years:
   a. balance sheet;
   b. statement of income and expense;
   c. statement of changes in capital and surplus;
   d. cash flow;
   e. capital expenditure; and
   f. repayment schedule for existing or anticipated loans or alternative financing arrangements.

   The projection for year one shall consist of actual results for quarter one as well as a projection for quarters two, three and four. The projections for years two and three shall be on an annual basis. The format shall be consistent with that specified for the quarterly reporting filings and unaudited annual reports required to be filed with the Commissioner pursuant to 211 CMR 43.05(2) and (3)
3. A statement indicating when the HMO estimates that enrollment and other income from operations will equal expenses;

4. Projections must be accompanied by detailed statements of underlying assumptions used and the bases thereof, including, but not limited to, projected premium rates and documentation as required for premium rates. If available, independent evaluations and assessment of these statements should also be included;
5. A copy of the vote, or portion thereof, of the Board of Directors or governing body of the HMO designating the permissible forms of investments of HMO funds and any limitations thereon;
6. Letters of financial support, credit, bond, or loan guarantee or other financial guarantee to the applicant;
7. A detailed statement of the HMO's plan to establish and maintain reserves or other funds as determined necessary to cover any risks projected and not otherwise assumed by another entity, carrier or reinsurer; a detailed statement of current and projected reserve establishment calculations, amounts, purpose and use of reserve, and assumptions and bases thereof, including, but not limited to, identification of reserves set aside to meet uncovered reinsurance items;
8. Plans for a surety bond or a deposit of cash or sureties in at least the same amount as a guarantee that the obligation to the members will be performed, unless waived as provided in M.G.L. c. 176G, §15;
9. Copies of all reinsurance, conversion or other agreements with other insurers, health providers, medical service corporations, hospital service corporations, governmental agencies or organizations or other HMOs to provide payment for the cost of, or to provide the contracted for health care services in the event the HMO is unable or ceases to provide contracted for health services for any reason;
10. A copy of the HMO's official notification of status as a federally qualified HMO if it is so designated.
11. A statement of insurance or funded self-insurance coverage for:
    a. protection against loss of property and liability of the HMO;
    b. worker's compensation to protect against claims arising from work-related injuries; and
    c. medical malpractice liability insurance of the HMO and providers;
12. A listing of shareholders or other equity holders or members with holdings of five percent or more of capital shares, partnership interest or other evidence of equity holdings, by name, address, number and percentage of shares or other interest held and any other affiliations with the HMO;
13. A listing of the applicant's legal, accounting and actuarial representatives by name and address;
14. A statement of the plan's accounting system and organization, management and internal controls, method of estimating and handling incurred but not reported liabilities;
15. A statement of fidelity bond coverage of all officers and employees entrusted with the handling of funds; and
16. A detailed description of mechanisms to monitor the financial solvency of any independent practice association, group practice, or other organization contracting with the HMO that assumes substantial financial risk through capitation or other prepaid risk-sharing or risk-transferring arrangements, where substantial financial

risk shall mean prepayments totaling more than five percent of an HMO's annual health care expense.

[The following documents may be requested by the Commissioner, but need not be submitted unless such request is made:]

17. Current financial statements for guarantors of the HMO's contractual obligations;
18. Current financial statements for persons or providers or corporate entities which have contracted with the HMO for the provision of medical, administrative, or marketing services, audited if available; and
19. A current financial statement of any person who holds a financial interest in the HMO.
20. Any additional information as deemed necessary by the Commissioner.

(i) Evidence of Compliance with M.G.L. c. 176O and 211 CMR 52.00.

1. Any HMO accredited by the Managed Care Bureau shall be deemed to meet the utilization review requirements of M.G.L. c. 176O and 211 CMR 52.00.

(j) Filing fee.

1. For initial applications, the filing fee as determined by the Executive Office for Administration and Finance and set forth in 801 CMR 4.02.
2. For renewal applications, a filing fee in the amount of $500.

(2) Review of Application. Upon receipt of a complete application, the Commissioner shall review the submitted material to determine whether a license shall be granted or renewed. The organization must demonstrate evidence of meeting all requirements set forth in M.G.L. c. 176G, M.G.L. c. 176O, 211 CMR 43.00 and 211 CMR 52.00 including the following:

(a) Corporate and organizational structure capable of supporting the benefits offered;
(b) Compliance with requirements for determination of need and facilities licenses;
(c) Power of authority authorizing Commissioner to accept service of process for any legal actions commenced against HMO not domiciled in Massachusetts;
(d) Contractual agreements that adequately protect the interests of members;
(e) Utilization systems ensuring the appropriate and efficient use of health services;
(f) Quality assurance systems monitoring the quality of care provided to members;
(g) Operations financially capable of meeting the risk of providing health services;
(h) Clear and logical plan for marketing of the HMO products;
(i) Adequate provider networks to guarantee that all services contracted for will be accessible to members without delays detrimental to the health of members; and
(j) Sufficient financial reserves or other resources to meet its financial obligations.

(3) Approval of License. Each license issued under M.G.L. c. 176G and 211 CMR 43.00 shall remain in effect for 12 months unless revoked or suspended by the Commissioner.

(a) For renewal licenses issued for periods following January 1, 2003, renewal applications must be submitted by July 1 of each year for a renewal date of January 1. The Division will notify all HMOs regarding the status of their HMO license renewals by November 1 of each year.
(b) For licenses issued on or after January 1, 2001, renewal applications must be submitted at least 90 days prior to the anniversary date of the initial approval.

(4) Denial of License. If an application for a license is denied, the Commissioner shall notify the organization in writing, stating the reason(s) for the denial. The organization shall have the right to a hearing on its application within 45 days of its receipt of such notice by filing a written request for hearing within 15 days of its receipt of such notice. Within 15 days after the conclusion of the hearing, the Commissioner shall either grant a license or shall notify the organization in writing of the denial of a license stating the reason(s) for the denial. The organization shall have the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, §14.

(5) Nonrenewal of License. If an application for a license renewal is denied, the Commissioner shall notify the organization in writing, stating the reason(s) for the nonrenewal. The organization shall have the right to a hearing on its application within 45 days of its receipt of such notice by filing a written request for hearing within 15 days of its receipt of such notice. Within 15 days after the conclusion of the hearing, the Commissioner shall either renew the license or shall notify the organization in writing of the nonrenewal of a license stating the reason(s) for the nonrenewal. The organization shall have the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, §14. During the period following the initial notice of nonrenewal, the HMO may be required to cease offering new business or may be placed under administrative supervision.

(6) Administrative Supervision, Revocation or Suspension of License. If the Commissioner finds, upon examination or other evidence submitted to him or her, that any HMO is in an unsound condition, or that it substantively fails to comply with the requirements of M.G.L. c. 176G, 211 CMR 43.00, or any other provision of law or regulation, he or she may suspend or revoke its license, or place the HMO under administrative supervision.
   (a) Before any such action is taken, the Commissioner shall notify the HMO in writing of his or her intention to take action and the date and place for a hearing on the matter. If the Commissioner finds that an emergency exists requiring immediate action he or she may order suspension of the HMO's license pending further proceedings or place the HMO under administrative supervision, as set forth in M.G.L. c. 175J.
   (b) Following the hearing, the Commissioner shall notify the HMO in writing of any decision regarding administrative supervision or the revocation or suspension of its license. The HMO has the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, §14.

(7) Rehabilitation or Liquidation. The Commissioner may institute the rehabilitation or liquidation of any HMO pursuant to M.G.L. c. 176G, § 20 if he or she finds, upon examination or other evidence submitted to him or her, any of the following:
   (a) the HMO is insolvent or in unsound financial condition;
   (b) the HMO's business policies or methods are unsound or improper;
   (c) the HMO's condition or management is such as to render its further transaction of business hazardous to the public or to its members or creditors;
   (d) the HMO is transacting business fraudulently;
   (e) the HMO or its officers or agents have refused to submit to an examination;
   (f) the HMO has attempted or is attempting to compromise with its creditors on the ground that it is financially unable to pay its claims in full; or

(g) the HMO has inadequately reserved for unearned premiums.

43.05: Reporting

(1) Financial concerns. Each HMO shall inform the Commissioner of any extraordinary loss or claim which has the potential to render it unable to meet its obligations as they become due, within five business days of its occurrence.

(2) Quarterly filings. An HMO shall file three copies of a quarterly report with the Commissioner within 45 days of the close of its quarter in the format specified by the NAIC or otherwise as specified by the Commissioner.

(3) Unaudited annual reports. Each year, every HMO shall file with the Commissioner, within 60 days of the close of its fiscal year, three copies of a report covering its preceding fiscal year that is verified by at least two principal officers in the format specified by the NAIC or otherwise specified by the Commissioner; provided, that if the Commissioner determines that a threat of insolvency exists to the HMO, he or she may require that such report be made available prior to the expiration of 60 days.

(a) Such annual report shall be made on the latest applicable form of annual statement approved by the NAIC, with any additional information the Commissioner may require for filing with the NAIC for the purpose of eliciting a complete and accurate exhibit of the condition and transactions of the company. All financial information reflected in the annual statement shall be maintained and prepared in accordance with accounting practices and procedures prescribed or permitted by the Commissioner. The Commissioner shall require that the annual statement be maintained and prepared in accordance with the Annual Statement Instructions and Accounting Practices and Procedures Manual adopted by the NAIC unless further modified by the Commissioner as he or she considers appropriate. The annual statement shall be subscribed and sworn to by its president and secretary or, in their absence, by two of its principal officers. The Commissioner may at other times require any such statements as he or she may deem necessary.

(b) Each domestic and foreign HMO authorized to transact insurance in Massachusetts shall annually on or before March first, file with the NAIC a copy of its annual statement convention blank, along with such additional filings as prescribed by the Commissioner for the preceding year. The information filed with the NAIC shall be in the same format and scope as that required by the Commissioner and shall include the signed jurat page and the actuarial certification. Any amendment or addendum to the annual statement filing subsequently filed with the Commissioner shall also be filed with the NAIC. Foreign HMOs that are domiciled in a state that has a law substantially similar to 211 CMR 43.05 shall be deemed to be in compliance with 211 CMR 43.05.

(c) The provisions of 211 CMR 43.05(3) shall apply to all domestic, foreign and alien HMOs that are authorized to transact business in Massachusetts.

(4) Audited annual reports. All HMOs shall have an annual audit by an independent certified public accountant and shall file an audited financial report, prepared in accordance with generally accepted accounting principles, with the Commissioner on or before 120 days of the

close of the preceding fiscal year. Extensions of the filing date may be granted by the Commissioner for 30-day periods upon showing by the HMO or its independent certified public accountant valid justification for such extension. The request for any extension must be received prior to the due date of the audited financial report in sufficient detail to permit the Commissioner to make an informed decision with respect to the requested extension.

(a) Designation of Independent Certified Public Accountant. All HMOs shall notify the Commissioner of the engagement of a certified public accountant within 30 days of such appointment if such accountant was not the accountant for purposes of 211 CMR 43.00 for the immediately preceding year. Such notification shall include a statement by the president, treasurer and chairman of the audit committee (if any) as to whether in the 24 months preceding the most recent year end, there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosures, or auditing procedures which disagreements if not resolved to the satisfaction of the former accountant would have caused him to make reference to the subject matter of the disagreement in connection with his opinion. The HMO shall also in writing request such former accountant to furnish it with a letter addressed to the Commissioner stating whether he agrees with the statements contained in its letter and, if not, stating the reasons why he does not agree. The HMO shall furnish such responsive letters from the former accountant to the Commissioner together with its own.

(b) Qualification of Independent Certified Public Accountant. The Commissioner shall not recognize any person or firm as an independent certified public accountant who is not duly licensed to practice and in good standing under the laws of Massachusetts (or in a state with licensing requirements similar to Massachusetts) and a member in good standing of the American Institute of Certified Public Accountants. Except as otherwise provided herein, a certified public accountant shall be recognized as independent as long as he conforms to the standards of his profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants, and Rules and Regulations and Code of Ethics and Rules of Professional Conduct of the Massachusetts Board of Public Accountancy (or similar code). The Commissioner may hold a hearing to determine whether a certified public accountant is qualified under 211 CMR 43.00, whether he or she is independent, whether an audit performed by him or her conforms to generally accepted auditing standards, or whether the annual audited financial report on which he has given his or her opinion presents fairly the financial position and results of operations of the HMO. After a negative ruling on any of the above issues, the Commissioner may require the HMO to replace the accountant.

(c) Availability and Maintenance of Working Papers of the Independent Certified Public Accountant. HMOs shall require the independent certified public accountant to make available for review by the Commissioner or his or her appointed agent, the work papers prepared in the conduct of the audit which shall include its parent and affiliates as they relate to the examination of the HMO. The HMO shall require that the accountant retain the audit work papers for a period of not less than five years after the period reported upon. The records of any such audit, examination, or other inspection and the information contained in the records, reports, or books of an HMO shall be confidential and open only to the inspection of the Commissioner and his or her examiners and assistants, except to the extent that production of such records is required by law in a civil or criminal proceeding affecting the HMO. The final report of any such audit, criminal proceeding, or other inspection by or on behalf of the Commissioner shall be a public record.

The aforementioned reviews by the Commissioner shall be considered investigations and all working papers obtained during the course of such investigations shall be confidential. If the Commissioner considers them to be relevant, the HMO must require that the independent certified public accountant provide photocopies of any of his or her working papers and these papers may be retained by the Commissioner.

"Working Papers", as referred to in 211 CMR 43.05(4)(c), include, but are not necessarily limited to, schedules, analyses, reconciliations, abstracts, memoranda, narratives, flow charts, copies of company records or other documents prepared or obtained by the accountant and his employees in the conduct of their examinations of the HMO.

(d) Annual Audited Financial Report. The report shall include:

1. Opinion of the Independent Certified Public Accountant.
2. Audited Financial Statements, including:
    a. balance sheet;
    b. statement of income and expense;
    c. statement of cash flows;
    d. statement of changes in capital and surplus; and
    e. notes to financial statements.
    f. In general, and except as otherwise provided herein, the financial statements filed pursuant to 211 CMR 43.05(2) should be prepared as follows:
        i. The financial statements shall be comparative, presenting the amounts as of the last date of the current year and the amounts as of the year end immediately preceding.
        ii. If the HMO is included in consolidated or combined financial statements prepared on the basis of generally accepted accounting principles, such financial statements must also be included in the filing of the audited financial report. An HMO may make written application to the Commissioner for approval, at his or her discretion, to file an annual audited consolidated or combined financial report in lieu of a separate annual audited financial report for the HMO. In such cases, and in cases of HMOs that have subsidiaries that are required to be consolidated under generally accepted accounting principles, the annual audited financial report shall include a columnar consolidating or combining worksheet, as follows:
            - amounts shown on the consolidated or combined audited financial report shall be shown on the worksheet;
            - amounts for the HMO shall be stated separately;
            - non-HMO operations may be shown on the worksheet on a combined or individual basis; and
            - explanations of consolidating and eliminating entries shall be included.
        iii. A reconciliation shall compare the amounts shown in the HMO columns of the worksheet with comparable amounts in the HMO's annual statement of financial condition.

3. Report of Significant Deficiencies in Internal Controls. In addition to the annual audited financial statements, each HMO shall furnish the Commissioner with a written report prepared by the accountant describing significant deficiencies in the HMO's internal control structure noted by the accountant during the audit. SAS No. 60, Communication of Internal Control Structure Matters Noted in an Audit (AU Section 325 of the Professional Standards of the American Institute of Certified Public Accountants) requires an accountant to communicate significant deficiencies (known as "reportable conditions") noted during a financial statement audit to the appropriate parties within an entity. No report need be issued if the accountant does not identify significant deficiencies. If significant deficiencies are noted, the written report shall be filed annually by the HMO with the Division. The HMO is required to provide a description of remedial actions taken or proposed to correct significant deficiencies, if such actions are not described in the accountant's report.

(e) Notification of Adverse Financial Condition. HMOs subject to 211 CMR 43.00 shall require the independent certified public accountant to immediately notify in writing an officer and all members of its Board of Directors of any determination by the independent certified public accountant that the HMO has materially misstated its financial condition as reported to the Commissioner for the fiscal year ended immediately preceding. The HMO shall furnish such notification to the Commissioner within five days of receipt thereof. If the accountant, subsequent to the date of the audited financial report pursuant to 211 CMR 43.05(4)(d) 2., becomes aware of facts which would have affected his or her report, the Commissioner notes the obligation of the accountant to take such action as prescribed by Section 561 of the Statement of Auditing Standards Number One of the American Institute of Certified Public Accountants.

(5) Examination by the Commissioner. The Commissioner shall determine the nature, scope and frequency of examinations conducted pursuant to M.G.L. c. 176G, § 10. Such examinations may cover all aspects of the HMO's assets, condition, affairs and operations and may include and be supplemented by audit procedures performed by independent certified public accountants as herein provided.

(a) The type of examinations performed by the Commissioner's examiners may include, but shall not be limited to, the following:

1. Financial surveillance will consist of a review of the audited financial report and annual statement and may include a review of the independent certified public accountant's working papers if expressly required and a general review of the HMO's corporate affairs and operations to determine compliance with Massachusetts General Laws and the Rules and Regulations of the Commissioner. The examiners may perform alternative or additional examination procedures to supplement those performed by the independent certified public accountants when the examiners determine that such procedures are necessary to verify the financial condition of the HMO;
2. Targeted examinations will cover specific areas of an HMO's operations as the Commissioner may deem appropriate; and
3. Comprehensive examinations will be performed when the report of the accountant as provided for in 211 CMR 43.05(4)(d) or the notification required

by 211 CMR 43.05(4)(e) or the results of financial surveillance or targeted examinations or other circumstances indicate in the judgment of the Commissioner that a complete examination of the condition and affairs of the HMO is necessary. Such examinations may be conducted by the Commissioner or his or her appointed agent.

(b) At the completion of each examination described above, the examiner appointed by the Commissioner shall make a full and true report on the results of the examination. Each report shall include a general description of the scope of the examination performed and the extent to which the examiners utilized the work of the HMO's accountants or other certified public accountants to supplement their examination. The cost of all work performed by independent certified public accountants shall be borne by the HMO.

(6) Exemptions. Upon written application of any HMO, the Commissioner may grant an exemption from compliance with 211 CMR 43.05 or portions thereof if the Commissioner finds, upon review of the application, that compliance with 211 CMR 43.00 would constitute a financial or organizational hardship upon it or its independent certified public accountant. An exemption may be granted at any time for any specified period. Within ten days of receipt of a denial of a written request for an exemption from 211 CMR 43.00, the HMO may request in writing a hearing on its application for exemption. Such hearing shall be held in accordance with M.G.L. c. 30A and the practices of the Commissioner pertaining to administrative hearings.

(7) Material Changes. All material changes to information contained in the HMO's application, including but not limited, to the HMO's articles of incorporation and by-laws, Board of Directors, management structure or key management personnel, investment guidelines, letters of financial support, service area, amendments to the evidence of coverage, significant changes to provider networks, the name under which the HMO does business, and all changes in controlling interest of the HMO, shall be submitted to the Commissioner on or before their effective dates.

(8) Additional Reports. The Commissioner, if he or she so determines the need exists, may require the HMO to submit additional reports other than those specifically required by 211 CMR 43.00.

43.06: Premium Rates

Each HMO shall submit proposed rates and benefits, or changes thereof, on or before their effective dates and at least at the beginning of each calendar quarter. Submissions are subject to the Commissioner's disapproval if the benefits and rates do not meet the requirements of M.G.L. c. 176G, § 16. If the Commissioner requires additional information to review the rates, he or she will contact the HMO.

43.07: Evidence of Coverage

(1) The evidence of coverage for each product offered by the HMO must be submitted to the Commissioner, and is subject to the disapproval of the Commissioner if it does not meet the requirements of M.G.L. c. 176G, M.G.L. c. 176O, 211 CMR 43.00, 211 CMR 52.13.

43.08: Agents

(1) All agents of licensed HMOs must be duly licensed to sell accident and health insurance products pursuant to M.G.L. c. 175, § 163.
(2) Nothing in 211 CMR 43.08(1) shall require an HMO to appoint agents.

43.09: Books and Records

Every HMO shall keep and maintain its books of account and other records on a current basis and within Massachusetts. In addition, every HMO shall make, or cause to be made, and retain books and records which accurately reflect:

(1) The names and last known addresses of all current subscribers to the HMO;

(2) All contracts required to be submitted to the Commissioner and all other contracts entered into by the HMO;

(3) All requests made to the HMO for payment of monies for health care services, the date of such requests, and the dispositions thereof;

(4) The names and last known addresses of persons who solicit or obtain members for an HMO, including but not limited to employees, brokers and agents;

(5) The amount of any commissions paid to persons who obtained members for the HMO and the manner in which said commissions are determined; and

(6) the total number and disposition of malpractice claims and other claims relating to the service or care rendered by the HMO made by, or on behalf of, members of the HMO that were settled or resulted in a judgment during the year by the HMO.

Every HMO shall preserve for a period of not less than five years, the last two years of which shall be in an easily accessible place at the main offices of the HMO, the books of account and other records required under the provisions of, and for the purposes of 211 CMR 43.00. After such books and records have been preserved for two years, they may be stored subject to their availability to the Commissioner not more than five days after he or she may request them.

43.10: Penalties

(1) If the Commissioner issues a finding of neglect on the part of an HMO, the Commissioner shall notify the HMO in writing that the HMO has failed to make and file the materials required by M.G.L. c. 176G, M.G.L. c. 176O, 211 CMR 43.00 or 211 CMR 52.00 in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the Commissioner shall fine the HMO $5000 for each day during which the neglect continues.

(2) Following notice and hearing, the Commissioner shall suspend the HMO's authority to do new business until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the finding of neglect can be removed.

43.11: Severability

If any provision of 211 CMR 43.00 or application thereof to any regulatee is held invalid, such invalidity shall not affect other provisions of 211 CMR 43.00 and, to that end, the provisions of 211 CMR 43.00 are severable.

REGULATORY AUTHORITY

211 CMR 43.00: M.G.L. c. 175J, § 9; c. 176D, § 11, c. 176G, § 17 and M.G.L. c. 176O, §17.